PRINTED: 12/03/2015
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN3003	A. BUILDING: _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUGHLIN HEALTH CARE CENTER	801 E MCKEE ST - GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A licensure survey was completed at Laughlin Health Care center, on 11/16-18/15. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	**1200-8-6 N 000 Initial Comments Laughlin Healthcare Center acknowledges that on the Licensure Survey completed on 11/16-18/15, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.**	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrative Assistant Manager	12/9/15